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Military Medical Care Services: Questions and Answers

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CONTENTS

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SUMMARY

The primary mission of the Military Health Services System (MHSS) which encompasses the Defense Department's hospitals, clinics, and medical personnel, is to maintain the health of military personnel so they can carry out their military missions, and to be prepared to deliver health care during wartime. The military medical system also provides, where space is available, health care services in Department of Defense (DOD) medical facilities to dependents of active duty service members and to retirees and their dependents.

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is the military equivalent of a health insurance plan, run by DOD, for active duty dependents, military retirees, and the dependents of retirees, survivors of deceased members, and certain former spouses. CHAMPUS reimburses beneficiaries for portions of the costs of health care received from civilian providers.

DOD is currently implementing a new management initiative, **Tricare**, to coordinate the efforts of the services' medical facilities. Tricare will also provide beneficiaries with the opportunity to receive their care through a DOD-managed health maintenance organization, a preferred provider organization, or to continue to use regular CHAMPUS (now known as Tricare Standard).

The MHSS currently includes some 102 hospitals and 489 clinics operating worldwide and employs more than 42,000 civilians and 102,000 active duty military personnel. For FY1999, appropriations for military medicine totaled some $15.5 billion (including $5.3 in military personnel costs and $3.5 billion for CHAMPUS and Tricare Managed Care Support Contracts). Projected FY2000 spending is slightly higher.

As conceived, CHAMPUS was intended in part to provide retirees with health care benefits from the time of their retirement, usually in their mid-40s, until they became eligible for Medicare at age 65. Various proposals have been submitted to continue Tricare/CHAMPUS coverage after age 65. One widely discussed proposal, known as Medicare Subvention, would direct Medicare to reimburse DOD for care provided at military facilities to Medicare-eligible beneficiaries. This step would, proponents argue, provide the funding necessary to make DOD care available to far more beneficiaries.

A demonstration of Medicare subvention at six sites was authorized by the Budget Reconciliation Act passed in August 1997 and implementation began in mid-1998. Critics of subvention believe that it might shift the mission of the Defense Health Program away from its emphasis on the medical readiness of active forces as well as increasing costs to the government.

Many retirees groups advocate opening the Federal Employees Health Benefits Program (FEHBP) to military retirees. The Administration expressed opposition because of cost considerations, but an FEHBP demonstration project was created by FY1999 Defense authorization legislation.

MOST RECENT DEVELOPMENTS

The FY2000 Defense Authorization Act (P.L. 106-65), signed October 5th , includes a number of initiatives regarding military health care with particular attention to improving the pharmacy benefits program. It asks for a study of a design for a comprehensive pharmacy plan for Medicare-eligible beneficiaries. The FY2000 Defense Appropriations Act (P.L. 106-79), signed October 25th, provided funding for the Defense Health Program at levels slightly higher than those requested by the Administration.

BACKGROUND AND ANALYSIS

Although the Military Health Services System (MHSS) is primarily designed to provide medical services to active duty service members, it is also a major source of medical care, in both military and civilian facilities, to the dependents of active duty personnel, military retirees, and retirees' dependents. Since 1967 civilian care to millions of dependents and retirees (and retirees' dependents) has been provided through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) although beneficiaries are responsible for certain copayments. Since 1995 the Department of Defense (DOD) has sought to coordinate the medical care efforts of the Army, Navy, and Air Force, and to institute managed care principles in a program known as Tricare. Tricare provides beneficiaries with the opportunity of choosing a health maintenance organization option, a preferred provider option, or a fee-for-service option.

The implementation of Tricare and other efforts to manage DOD health care more efficiently as well as downsize the MHSS as part of the overall post-cold war reductions of the entire Defense Department, has meant that less care is available to non-active duty beneficiaries, especially to those over age 65. Informed, articulate, and well-organized, this population—and the Clinton Administration—have sought authorization to obtain reimbursement for DOD from Medicare for medical services provided to beneficiaries over age 65. Known as Medicare subvention, this proposal has wide bipartisan support in Congress; a demonstration project was authorized in the Budget Reconciliation Act signed in August 1997. Important questions remain, however, regarding the potential implications for the Medicare Trust Fund and upon the functioning of the MHSS itself.

This issue brief attempts to answer basic questions about the MHSS, its beneficiary population, the medical services it provides, its costs, and major changes that are underway or have been proposed. Citations are made to more detailed CRS studies where appropriate. The General Accounting Office (GAO) and the Congressional Budget Office (CBO) have also published important studies. In addition, the Office of the Assistant Secretary of Defense for Health Affairs Home Page may be of interest. [http://www.tricare.osd.mil/]

Questions and Answers

1. What Is the Purpose of the Military Health Services System?

The MHSS provides medical care to active duty military personnel, eligible military retirees, and eligible dependents of both groups. The primary mission of the medical services system is to maintain the health of military personnel, so they can carry out their military missions, and to be prepared to deliver health care required during wartime. Often described as the medical readiness mission, this effort involves medical testing and screening of recruits, emergency medical treatment of servicemen and women involved in hostilities, and the maintenance of physical standards of those in the armed services.

In support of those in uniform, the military medical system also provides, where space is available, health care services to dependents of active duty service members. Space available care is also provided to retirees and their dependents. Some former spouses are also included. Since 1966 civilian medical care for dependents of active duty personnel, and for retirees and their dependents who are under age 65 has been available (with certain limitations and co-payments) through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). CHAMPUS is currently being incorporated in the Tricare program that is designed to coordinate health care services of the uniformed services with civilian providers.

2. What is the Structure of the Military Health Services System?

Under the Secretary of Defense, the MHSS is headed by the Assistant Secretary of Defense for Health Affairs (ASD/HA). An October 1991 reorganization strengthened the role of the ASD/HA by giving the incumbent planning, programming, and budgeting responsibilities for the MHSS, including facilities operated by the Army, Navy (which also provides health care services to the Marine Corps), and Air Force. The Surgeons General of the Army, Navy and Air Force retain considerable responsibility for managing military medical facilities and personnel.

The MHSS currently includes some 102 hospitals, and 489 clinics operating worldwide and employs more than 42,000 civilians and 102,000 active duty military personnel. In FY1999 the Defense Department was authorized $15.5 billion for health care spending (including $5.4 in military personnel costs). Direct care costs include the provision of medical care directly to beneficiaries, the administrative requirements of a large medical establishment, and maintaining a capability to provide medical care to combat forces in case of hostilities. Total figures include some $3.5 billion incurred for health care obtained from civilian providers.

Although the number of active duty personnel in the Department of Defense (DOD) is not projected to increase over the next few years, costs associated with the MHSS are not expected to follow suit. This results from general inflation in the cost of health care and an increasing percentage of care being provided to retirees and their dependents. (In 1950 retirees made up 8% of those eligible for military health care; by 1997 it was over 50%.) Reductions in direct care can actually lead to growth in overall DOD health spending because beneficiaries whose access to military medical facilities is removed through base closures may

turn to more costly care from civilian providers, for which they can seek reimbursement from DOD.

Each year the Office of the Secretary of Defense (OSD) forwards a budget request to Congress for the Defense Health Program (DHP) which includes monies needed for procuring equipment for the MHSS, operation and maintenance, and care for civilian beneficiaries. Funding for the compensation of military personnel assigned to the MHSS is contained in the Military Personnel appropriation accounts of the individual military departments. Additional requests are made in procurement and military construction accounts. For FY1999 the Administration requested an overall figure of $15.6 billion, of which $5.2 billion were for military personnel costs, and $3.5 billion to CHAMPUS and Tricare Managed Care Support Contracts. The FY1999 Defense Appropriations Act (P.L. 105-262) essentially approved the requested level of funding and an additional $200 million was added in the Omnibus Appropriations Act passed in October 1998 to compensate for "funding shortfalls."

Concern about the costs of military medical care continues. For a decade, CHAMPUS costs grew dramatically, tripling from $1.2 billion in FY1984 to an estimated $3.9 billion in FY1994, with the percentage of DOD health care costs allocated to CHAMPUS also increasing. Cost containment measures, along with DOD downsizing, have, however, led to slight reductions in CHAMPUS spending in recent years. The advent of Tricare was designed in part as a cost-savings measure, but its success in that regard has not yet been demonstrated. In February 1997 GAO concluded that "future Defense Health Program costs are likely to be greater than DOD has estimated." (See GAO, *Defense Health Program: Future Costs are Likely to be Greater than Estimated*, GAO/NSIAD-97-83BR.)

Congressional and other observers express concern about levels of funding for military medical care in the future, given budgetary limitations that are expected to constrain all defense programs. Some observers have proposed limiting DOD medical services to those essential to potential wartime medical needs and to serve the peacetime needs of the active duty population, but not dependents and retirees. A Congressional Budget Office analysis has concluded that such restrictions could eventually save $2 billion a year. (See Congressional Budget Office, *Paying for Military Readiness and Upkeep: Trends in Operation and Maintenance Spending*, September 1997, p. 49.)

3. How Much Does Military Health Care Cost Beneficiaries?

Active duty service members receive covered medical care in military facilities without additional costs, other than small *per diem* ($10.45 in FY1999) charges. Other beneficiaries pay differing amounts depending on their status and where they receive care. If care can be obtained at military facilities, there is no charge for medical services, and only small daily charges for hospital stays.

Tricare costs vary by the option selected. Active duty personnel are automatically enrolled in Tricare Prime without any premiums; their dependents may join, also without premiums. Retirees (under age 65) must pay $230 (individual) or $460 (family) each year in enrollment fees. There are small fees required for visits to civilian care providers who are part of the Tricare network. Inpatient care involves fees of $9-11 daily (with some exceptions).

Tricare Standard or CHAMPUS has a more complicated cost structure. There are no premiums or enrollment fees. At present, for outpatient care in civilian hospitals and clinics, there is a yearly deductible of $150.00 for one person and $300.00 for a family. After the yearly deductible is met, dependents of active duty personnel pay 20% of CHAMPUS-approved care; all others pay 25%. For inpatient care, there is no deductible for CHAMPUS-approved care, but families of active duty service members pay $25.00 per stay (or a small *per diem*). Other CHAMPUS beneficiaries will pay the lesser of 25% of the billed charges or a fixed daily amount ($376. in FY1999) of care covered by CHAMPUS. In addition, there is a "cap" on annual care; active duty families are reimbursed for allowable expenses over $1000 and other CHAMPUS families are reimbursed for allowable expenses over $7,500. These figures are generalized; there are a number of important exceptions that are explained in the CHAMPUS Handbook and in the underlying Federal Regulations (32 CFR 199). The Handbook urges beneficiaries to check with their Health Benefits Advisors before seeking care.

Tricare Extra, the preferred provider option, has a cost structure similar to CHAMPUS except that beneficiaries who use health care providers in the Extra network pay 5% less than they would if using non-network providers. Inpatient care costs $9.90 per day for active duty dependents and $250. per day (or 25% of daily hospital costs, whichever is less) for retirees and their dependents. Care may still be obtained from military facilities if space is available.

4. In What Ways Has the MHSS Been Changing in Recent Years?

During the Cold War, the MHSS was designed to support a full-scale, extremely violent war with the Soviet Union and its allies in Europe. High casualties were anticipated along with a need for in-theater medical treatment facilities. The collapse of the Soviet Union and the end of the Warsaw Pact led to a major reassessment of U.S. defense policy. In the future, defense planners believe, the most likely conflicts will be of limited duration and involve smaller numbers of troops. The overall size of the active duty force has been reduced by one-third since the mid-1980s. Planners expect that casualties can be treated locally (with greater reliance on telemedicine) or, if necessary, evacuated to military medical facilities in the continental United States (CONUS). This strategic planning, along with associated military personnel reductions, requires a smaller MHSS, fewer military medical personnel, and the closure of a number of hospitals and clinics. In recent years. the number of military medical personnel has declined by 15% and the number of military hospital has been reduced by one-third. (For background, see Department of Defense, Medical Readiness Strategic Plan, 1995-2001, March 30, 1995.)

The Quadrennial Defense Review (QDR) issued by DOD in May 1997 suggests that additional reductions in "defense agency and defense-wide infrastructure" are anticipated along with further outsourcing of elements of the Defense Health Program. The QDR did not, however, detail any major changes in military medical care despite earlier reports that it would recommend significant increases in enrollment fees for Tricare Prime.

On the other hand, the number of potential beneficiaries of military medical care who are over age 65 has grown in absolute terms to 1.2 million, and now represents about one-half of the beneficiary population. This number is expected to grow until 2009. Only those retirees ineligible for Medicare can use civilian providers and receive DOD reimbursement under Tricare and CHAMPUS. Most retirees become eligible for Medicare when they reach

age 65 although some disabled retirees become eligible for Medicare earlier. In 1991 Congress acted (in P.L. 102-190) to reestablish CHAMPUS eligibility for persons under age 65 who become eligible for Medicare, Part A because of disability. Such persons are, however, required to enroll in Medicare Part B (and pay premiums) to be eligible for CHAMPUS/Tricare. This requirement is currently being enforced with greater strictness although a special provision was included in the FY1999 Defense Authorization Act (section 704) to allow continued access to CHAMPUS eligibility until July 1999 for those who were previously unaware of the requirement to enroll in Part B.

In addition to revisions in military planning, nation-wide changes in the practice of medicine have also affected the MHSS. In particular, managed care initiatives and capitated budgeting that are widely adopted in the civilian community are being implemented in DOD's Tricare program. Tricare is also designed to coordinate medical care efforts of the three military departments in some 12 geographical regions, each under a single military commander known as a lead agent. The lead agents are responsible for managing care provided by all military medical facilities in their respective regions, and for contracting for additional care from civilian providers. These competitively-bid, region-wide contracts represent a significant change in delivery of defense health care and will, it is anticipated, result in cost savings. Each region will have a capitated budget based on the total number of beneficiaries in the region. Detailed regulations governing Tricare were made effective on November 1, 1995 (32 CFR 199). Although care continues to be centered around military medical facilities, heavy reliance will be placed on civilian contractors managed by the lead agent where necessary.

The centerpiece of Tricare is the Tricare Prime option, a DOD version of a health maintenance organization (HMO) that the beneficiary joins, and which provides essentially all of his or her medical care. Care is provided through DOD medical personnel, hospitals, and clinics, as well as affiliated civilian physicians, hospitals, and other providers. Costs are contained through administrative controls and treatment protocols. In civilian practice, HMOs have been credited with some success in reducing costs, although opponents of these systems complain about restrictions on provider choice and incentives that may be created to constrain the delivery of services.

CHAMPUS/Tricare Standard has been the military equivalent of a health insurance plan, run by DOD, for active duty dependents, military retirees, and the dependents of retirees, survivors of deceased members, and certain former spouses (for more information on those benefits available to former spouses, see CRS Report 94-778, *Military Benefits for Former Spouses: Legislation and Policy Issues*, by David F. Burrelli). Unlike private insurance plans, CHAMPUS/Tricare Standard does not require premiums. If care at a military facility cannot be provided (due to space limitations, limitations on the types of services that a facility is capable of providing, or due to the fact that a beneficiary may not live close enough to a military facility to make such travel reasonable), CHAMPUS/Tricare Standard will share responsibility with the beneficiary for the payment of care received from non-military health care providers, subject to regulations. If beneficiaries need inpatient care or certain types of outpatient care and live within a catchment area, i.e., a geographical area surrounding a military hospital, they must seek care first at that military medical facility and receive a document (known as a non-availability statement (NAS)) stating that the needed care was not available at that military facility, before CHAMPUS/Tricare Standard will pay a share of their

care at a non-military facility. Certain types of care, such as most dentistry and chiropractic services, are excluded.

In addition to CHAMPUS/Tricare Standard and Tricare Prime there is a preferred-provider option, Tricare Extra. In Tricare Extra beneficiaries do not enroll or pay annual premiums, but use physicians and specialists in the Tricare network and are charged 5% less for medical services.

The changes are intended to improve medical care available to the active duty population, but they will also result in less medical care available for the retired personnel and their dependents. The introduction of managed care may result in less space being available for over-65 retirees, who are eligible only for space-available care in military medical facilities. As a result, retirees and their organizations have been urging various measures that would permit expanded access (see below, question 8).

5. Who Is Eligible to Receive This Care?

Current law provides that active duty personnel are entitled to receive health care at military medical facilities. In addition, active duty dependents, military retirees and their dependents, and survivors of deceased members are eligible to receive health care at military medical facilities when space and professional services are available. Also eligible to receive care for a fixed fee in these facilities are certain government officials (including the President and Members of Congress) and certain foreign military personnel on active duty in the U.S. Reserve Component personnel and their dependents are also entitled to care in military medical facilities under certain conditions.

Since 1967 DOD has funded, under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), care by civilian providers to dependents, retirees, and dependents of retirees who are under age 65 and unable to obtain access in a military health facility. After 1991 DOD began, with Congressional support, moving towards managed care arrangements under the Tricare program that include greater use of civilian health care providers even for active duty personnel. CHAMPUS will continue but will be known as Tricare Standard.

6. How Are Priorities for Care in Military Medical Facilities Assigned?

Active duty personnel, military retirees, and their respective dependents are not afforded equal access to care in military medical facilities.

Active duty personnel are entitled to health care in a military medical facility (10 USC 1074).

According to 10 U.S.C. 1076, dependents of active duty personnel are “entitled, upon request, to medical and dental care” on a space-available basis at a military medical facility. Title 10 U.S.C. 1074 states that “a member or former member of the uniformed services who is entitled to retired or retainer pay ... may, upon request, be given medical and dental care in any facility of the uniformed service” on a space-available basis.

This language entitles active duty dependents to medical and dental care subject to space-available limitations. No such entitlement or "right" is provided to retirees or their dependents. Instead, retirees and their dependents may be given medical and dental care, subject to the same space-available limitations. This language gives active duty personnel and their dependents priority in receiving medical and dental care at any facility of the uniformed services over military members entitled to receive retired pay and their dependents. The policy of providing active duty dependents priority over retirees in the receipt of medical and dental care in any facility of the uniformed services has existed in law since at least September 2, 1958 (P.L. 85-861).

Subsequent to the establishment of Tricare and pursuant to the Defense Authorization Act of FY1996 (P.L. 104-106), DOD has established the following basic priorities (with certain special provisions):

Priority 1: Active-duty service members;
Priority 2: Active-duty family members who are enrolled in Tricare Prime;
Priority 3: Retirees, their family members and survivors who are enrolled in Tricare Prime;
Priority 4: Active-duty family members who are not enrolled in Tricare Prime;
Priority 5: All other eligible persons.

The priority is given to active duty dependents to help them obtain care easily, and thus make it possible for active duty members to perform their military service without worrying about health care for their dependents. This is particularly important for active duty personnel who may be assigned overseas or aboard ship and separated from their dependents. As retirees are not subject to such imposed separations, they are considered to be in a better position to see that their dependents receive care, if care cannot be provided in a military facility. Thus, the role of health care delivery recognizes the unique needs of the military mission. The role of health care in the military is qualitatively different, and, therefore, not necessarily comparable to the civilian sector.

The benefits (including Tricare/CHAMPUS) available to service members or retirees, which require comparatively little or no contributions from the beneficiaries themselves, are considered by some to be a more generous benefit package than is available to civil servants or to most people in the private sector. Retirees may also be eligible to receive medical care at Department of Veterans' Affairs (VA) medical facilities (see CRS Report RL30099, *Veterans Issues in the 106th Congress*, by Dennis W. Snook).

7. What is the Relationship of DOD Health Care to Medicare?

Active duty military personnel have been fully covered by Social Security and have paid Social Security taxes since Jan. 1, 1957. Social Security coverage includes eligibility for health care coverage under Medicare at age 65. It was the legislative intent of the Congress that retired members of the uniformed services and their eligible dependents be provided with medical care after they retire from the military, usually between their late-30s and mid-40s. CHAMPUS was intended to supplement — not to replace — military health care. Likewise, Congress did not intend that CHAMPUS should replace Medicare as a supplemental benefit to military health care. For this reason, retirees become ineligible to receive CHAMPUS benefits when at age 65 they become eligible for Medicare. Many argue that the structure is

inherently unfair because retirees lose Tricare/CHAMPUS benefits at the stage in life when they are increasingly likely to need them. Military retirees continue to be eligible for health care in military medical care facilities irrespective of age if space is available. Disabled persons under 65 who are entitled to Medicare may continue to receive CHAMPUS benefits as a second payer to Medicare Parts A and B (with some restrictions). For additional information regarding eligibility of Medicare eligible persons *under* age 65, see above, Question 4.

8. Have Military Personnel Been Promised Free Medical Care for Life?

Some military personnel and former military personnel maintain that they and their dependents were promised "free medical care for life" at the time of their enlistment. Such promises may have been made by military recruiters and in recruiting brochures; however, if they were made, they were not based upon laws or official regulations which provide only for access to military medical facilities for non-active duty personnel if space is available as described above. Space may not be available and Tricare options can involve significant costs to beneficiaries. Rear Admiral Harold M. Koenig, the Deputy Assistant Secretary of Defense for Health Affairs, testified in May 1993: "We have a medical care program for life for our beneficiaries, and it is pretty well defined in the law. That easily gets interpreted to, or reinterpreted into, free medical care for the rest of your life. That is a pretty easy transition for people to make in their thinking, and it is pervasive. We [DOD] spend an incredible amount of effort trying to re-educate people [that] that is not their benefit." (U.S. Congress, House of Representatives, Committee on Armed Services, Military Forces and Personnel Subcommittee, 103rd Congress, 1st session, National Defense Authorization Act for Fiscal Year 1994—H.R. 2401 and Oversight of Previously Authorized Programs, Hearings, H.A.S.C. No. 103-13, April 27, 28, May 10, 11, and 13, 1993, p. 505.)

Dr. Stephen C. Joseph, Assistant Secretary of Defense for Health Affairs until April 1998, however, argued that because retirees believe they have had a promise of free care, government did have an obligation. Joseph did not specify the precise extent of the obligation. The FY1998 Defense Authorization Act (P.L. 105-85) includes (in Sec. 752) a finding that "many retired military personnel believe that they were promised lifetime health care in exchange for 20 or more years of service," and expresses the sense of Congress that "the United States has incurred a moral obligation to provide health care to members and [retired] members of the Armed Services." Further, it is necessary "to provide quality, affordable care to such retirees." For additional background, see David F. Burrelli, *Military Health Care: the Issue of "Promised" Benefits,* CRS Report 98-1006, December 21, 1998.

9. Why is there widespread public interest in military medical care for retirees over age 65?

As noted above, military medical care is theoretically available to all retirees on a space-available basis. As a practical matter, however, the amount of space available to retirees over age 65 who are eligible for Medicare has become increasingly limited. This results from base closures, changing approaches to military medicine, and growth in the number of retirees. Retirees and retiree organizations have complained of being frozen out of military facilities, of being responsible for higher costs at a stage of life when more health care is required, and, especially, of the burden of having to pay for expensive pharmaceuticals that are taken on a regular basis.

Retirees and their spokesmen have urged several approaches to supplement or replace their Medicare benefits. First is Medicare subvention whereby Medicare would pay DOD for care provided to retirees over age 65 and thus provide revenues to encourage DOD to care for retirees. A second approach is to permit retirees to enroll in the Federal Employees Health Benefits Program (FEHBP). Another would provide national mail order pharmacy services to retirees. Some observers also seek to integrate DOD care with that provided by the Veterans Administration. Several of these proposals are discussed below; a Medicare subvention test was authorized by the Budget Reconciliation Act of 1997; tests of FEHBP for military retirees and access to a mail-order pharmacy plan as well as greater coordination between DOD and the VA were included in the FY1999 Defense Authorization Act (P.L. 105-261).

On January 14, 1999 the Defense Department announced **sites for the FEHBP demonstrations**. They are Dover Air Force Base, Delaware; Commonwealth of Puerto Rico; Fort Knox, Kentucky; Greensboro/Winston-Salem/High Point, North Carolina; Dallas, Texas; Humboldt County, California area; Naval Hospital, Camp Pendleton, California; and New Orleans, Louisiana. Beneficiaries can join the FEHBP during the fall 1999 open season and coverage will start in January 2000 and end in December 2002. Beneficiaries must enroll in an FEHBP plan and pay applicable premiums; the government's contribution will be computed the same as it has been for other FEHBP enrollees. Those eligible include over-65 retirees who are eligible for Medicare and their dependents, unremarried former spouses of military members, and dependents of deceased members or former members.

The FY1999 Defense Authorization Act (P.L. 105-261) also directed a demonstration project that would have Tricare serve as a supplement to Medicare. Scheduled to begin in April 2000 and last through the end of 2002, the **Tricare Senior Supplement Demonstration Program** will be conducted in Cherokee, Texas, and Santa Clara, California. Those who live in those locations and choose to participate will have to pay an enrollment fee (as well as join Medicare Part B), but Tricare will cover some costs that are not covered by Medicare.

10. What is Medicare Subvention? Should Medicare Reimburse DOD for Care Provided to Medicare-eligible Beneficiaries?

Current law generally prohibits Medicare from paying for services provided or paid for by another governmental entity (section 1862(a)(3) of the Social Security Act (42 USC 1395y)). Medicare subvention is the term given to proposals that Medicare (specifically, the Health Care Financing Administration (HCFA) of the Department of Health and Human Services) reimburse DOD for care provided to Medicare-eligible beneficiaries at DOD facilities or through Tricare. (It is estimated that currently some $1.2 billion annually is spent by DOD to provide care for Medicare-eligible beneficiaries.) In other words, when care is given by DOD to a retiree or dependent who is over age 65, Medicare would be asked to reimburse DOD according to an agreed-upon rate, much as Medicare would reimburse a civilian physician who provides care to an eligible person. (For additional information, see CRS Report 96-207, *Military Medical Care and Medicare Subvention Funding*, by David F. Burrelli and Tina Nunno.)

Advocates of Medicare subvention claim that military retirees, even those over age 65, were promised "free health care for the rest of their lives" by military recruiters and have

come to expect it, regardless of "legal technicalities." They argue that ending access to military medical facilities when beneficiaries reach an age when they will have greater need for it is fundamentally unfair. Reimbursement from Medicare will provide an important revenue source that will enable and encourage DOD to provide care to over-65 retirees. Further, it is argued that Medicare will save money because DOD can provide care less expensively than civilian providers (largely because of more austere facilities).

Opponents of Medicare subvention point out that there has never been a statutory guarantee that retirees and their dependents would have "free health care to the rest of their lives." In accordance with congressional intent, CHAMPUS has served as a health insurance system to cover military personnel until they became eligible for Medicare at age 65. Retirees over age 65, they note, continue to have access to military medical facilities on a space-available basis. A major concern is the widely perceived need to curtail rather than expand Medicare spending. Additional spending under a subvention proposal, if it was to be required, would necessitate further Medicare spending reductions. Some observers express concern that subvention could, in particular, lead to greater costs to Medicare if DOD care attracts beneficiaries who are currently using non-government health care plans. The transfer of funds from Medicare, an entitlement program, to the discretionary accounts of DOD, and thus subject to the annual authorization/appropriation process, would be complicated, given the provisions for budget enforcement. Further, some observers believe that giving DOD greater responsibilities for geriatric medicine may compete with its combat readiness mission.

In the 104th Congress, several Medicare subvention bills were introduced. Language in the FY1996 Defense Authorization Act expressed the sense of Congress that DOD should be reimbursed by Medicare for care given by DOD to Medicare-eligible beneficiaries in areas where Tricare is implemented. On June 20, 1996 the Senate approved an amendment to the FY1997 Defense Authorization bill (S. 1745) that required the Administration to submit by September 6, 1996 "a specific plan" for a demonstration project that would permit Medicare-eligible beneficiaries to enroll in the managed care Tricare option. Medicare would reimburse DOD on a capitated basis for beneficiaries who choose to enroll. The requirement for a plan for a demonstration project was included in the subsequent Conference version (H.R. 3230) and a draft plan was circulated by the Administration, but no mandate for implementing a plan was enacted in the 104th Congress and the legislation as signed (P.L. 104-201) did not authorize spending for a Medicare subvention demonstration project nor were funds appropriated for this purpose.

In the 105th Congress, Section 4015 of the Budget Reconciliation Act (P.L. 105-33), signed by the President on August 5, 1997, included complex provisions authorizing the establishment of a **three-year Medicare subvention demonstration project** at six sites. DOD would be reimbursed by Medicare at a rate equal to 95% of that paid to Medicare+Choice HMOs. The aggregate amounts to be reimbursed under this section will not exceed $50 million for FY1998, $60 million for FY1999, and $65 million for FY2000. The Act stipulates that "no new military treatment facilities will be built or expanded with funds from the demonstration project." Medicare HMOs are authorized to enter into contracts in which DOD will provide care to Medicare-eligible military retirees and their dependents and receive reimbursement from the HMOs. A separate component of the effort will allow retirees enrolled in a limited number of Medicare+Choice plans to contract with DOD military facilities to provide specialty and inpatient care to military retirees in those

plans. In the 106th Congress, legislation (H.R. 1067) has been introduced to extend Medicare subvention to the entire beneficiary population.

On February 12, 1998, the Administration announced that the Medicare subvention demonstration, to be known as **Tricare Senior Prime**, would be conducted at Keesler Air Force Base, Biloxi, Miss.; Brooke Army Medical Center and Wilford Hall Medical Center, San Antonio, Texas, Fort Sill, Lawton, Okla., Sheppard Air Force Base, Wichita Falls, Texas; Fort Carson and the Air Force Academy, Colorado Springs, Co.; Madigan Army Medical Center, Fort Lewis, Wash.; Naval Medical Center, San Diego, CA.; and Dover Air Force Base, Dover, Del. Enrollments for the Madigan demonstration began in July 1998; other sites were subsequently phased in. The FY2000 Defense Authorization Act (P.L. 106-65) includes a sense of the Congress provision stating that anyone enrolled in a DOD managed care program in one of the subvention areas should be automatically authorized to enroll in the Senior Prime demonstration program.

11. Should the Federal Employees Health Benefits Program (FEHBP) Be Open to Military Retirees?

Some have advocated making the health care plans for Federal civil servants and civil service retirees also available to Medicare-eligible military retirees instead of or in addition to Medicare subvention plans. The civil service system, known as the Federal Employees Health Benefits Program (FEHBP), is widely considered to be successful. It allows beneficiaries to choose among a number of health care plans. The government pays some 72% of the premiums and beneficiaries are responsible for the rest. (See CRS Report 94-615, *Federal Employees Health Benefits Program*, by Paul Graney.) Opening FEHBP to Medicare-eligible military retirees would cause minor administrative expenses, but subsidizing annual enrollment fees for retirees and their dependents over 65 could involve around $2 billion annually (if the government paid 72% of average premiums), according to a Congressional Budget Office estimate. On the other hand, an FEHBP option would allow retirees to choose the type of health care plan they prefer and it would not affect the delivery of military medical care to the active duty population. In addition, FEHBP plans would also ensure the availability of care in geographic areas that might not be reached by Tricare options. Some potential beneficiaries, however, would not be willing to make the substantial premiums that are required for participation in FEHBP.

Despite objections from the Defense Department, the FY1999 Defense Authorization Act (P.L. 105-261) included a FEHBP demonstration project limited to 66,000 participants in 6-10 geographic areas. (Beneficiaries would not be required to participate in Medicare Part B (which requires a monthly premium) but will be urged to do so.) At least one area will be near a Military Treatment Facility (MTF); one will not. One area will be an area in which a Medicare Subvention demonstration has been underway. There will be no more than one area for each Tricare region. Enrollees will have to pay the same level of premiums as paid by civil servants and agree not to seek care in MTFs during the length of the demonstration. The Defense Department will contribute the rest of the premiums. The demonstration project was scheduled to begin in January 2000 and run for three years; it will be evaluated by the Defense Department and the GAO. Legislation (H.R. 205, H.R. 1067, H.R. 2966) has been introduced in the 106th Congress that would extend FEHBP eligibility to all military retirees.

12. How Are User's Fees and Fee Schedules for Medical Services Assessed?

User's fees for medical services represent a means of generating revenues from those who use the services. In recent years user's fees, also known as co-payments, have been considered as a means of generating revenues in the military medical care system. Some observers see increased users' fees as a primary way to increase beneficiaries' cost-consciousness, arguing that far more than premiums and deductibles, cost-sharing discourages unnecessary medical services. The consideration of these fees has been subject to strong opposition from military personnel, retirees, and others who have viewed free or inexpensive health care as an important benefit of military service. To these individuals, user's fees represent an "erosion of earned benefits." Specifically, these benefits are not viewed by some beneficiaries as an insurance program paid for in a market context, but rather as a benefit that is earned by the unique nature of demands inherent in performing military service.

By law (P.L. 102-396), health care providers treating Tricare/CHAMPUS patients cannot bill for more than 115% of charges authorized by a DOD fee schedule. In some geographic areas, providers have been unwilling to accept Tricare/CHAMPUS patients because of the limits on fees that can be charged. DOD has authority to grant exceptions. Efforts have been made to bring payment levels for health care services provided by the MHSS into alignment with the Medicare's fee schedule. Over 90% of Tricare payment levels are now equivalent to those authorized by Medicare, about 10% are higher, and steps are being taken to raise some to Medicare levels.

13. What Will Be the Effect of Base Relocations and Closures on Military Medical Care?

Base relocations and closures undertaken as part of the restructuring of the Defense Department in the post-Cold War period have included changes in the military health services system. As a result of Base Realignment and Closure (BRAC) actions, 35% of the DOD medical treatment facilities providing services in 1987 were closed by the end of 1997 (although the number of eligible beneficiaries decreased by only 9%). Criteria for realignments and closures, established by DOD with congressional consent, include the need to deploy a force structure capable of protecting the national security, anticipated funding levels, and a number of military, fiscal, and environmental considerations that encompass community economic impact and community infrastructure. Three Base Realignment and Closure Commissions have specifically considered the effect of closing DOD hospitals and clinics on active duty military personnel as well as on other beneficiaries and potential beneficiaries of the MHSS. The first two BRAC Commissions recommended 18 military hospital closures; the third BRAC Commission recommended an additional 10. Facilities closed include hospitals in Philadelphia, PA; Oakland, CA; Orlando, FL; San Francisco, CA; Ft. Devens, MA; Ft. Ord, CA; and Long Beach, CA. In one case, the commission overruled a DOD proposal to close the Naval Hospital in Charleston, SC. (See CRS Report 95-435, *Military Retiree Health Care: Base Closures and Realignments*, by David F. Burrelli and Elizabeth A. Dunstan.)

With congressional encouragement, DOD has developed transition medical plans for certain closure sites. Medicare-eligible users of closed military hospitals will be encouraged to avail themselves of HMO and pharmacy programs established by the Department of Health

and Human Services or a mail-order pharmacy system being established by DOD. Nonetheless, the closure of military hospitals and clinics can be a source of anxiety, especially in communities that have attracted large numbers of new residents seeking access to the MHSS.

14. What is the DOD Pharmacy Benefit?

According to DOD officials, the pharmacy benefit is the one most in demand by beneficiaries. GAO estimates that it costs some $1.3 billion annually. Those with access to military treatment facilities and those who are enrolled in Tricare Prime receive prescribed pharmaceuticals free of charge. Users of Tricare Extra and Tricare Standard are reimbursed for pharmaceuticals in accordance with the same schedule of deductibles and co-payments for other medical services. Retirees over age 65 who do not have access to military facilities do not receive a DOD pharmacy benefit unless they live in a BRAC area for which special provisions have been made. Military pharmacies do not necessarily carry every pharmaceutical available; thus, even some with access to military facilities must have certain prescriptions filled in civilian pharmacies; those under 65 can be reimbursed through Tricare/CHAMPUS.

In October 1997 DOD implemented a National Mail Order Pharmacy Program that allows beneficiaries, except retirees over age 65 who do not live in a BRAC area, to obtain some pharmaceuticals by mail with small handling charges. The mail order program is designed to fill long-term prescriptions to treat conditions such as high blood pressure, asthma, or diabetes; it does not include medications that require immediate attention such as some antibiotics. According to one estimate by the GAO, providing the mail-order benefit to Medicare-eligible beneficiaries who do not currently have access to pharmaceuticals from DOD would cost some $230 million annually. A DOD estimate of the cost of providing the benefit to all Medicare-eligible beneficiaries would be $668 million per year. As DOD estimates it currently spends some $200 providing pharmaceuticals to this population, the additional annual cost would be $468 million.

A June 1998 GAO report, *Defense Health Care: Fully Integrated Pharmacy System Would Improve Service and cost-Effectiveness*, suggests that significant cost savings could be realized if DOD had a better database of pharmaceutical utilization and had a single, integrated delivery system rather than several independently managed ones. DOD has indicated that it concurs with the GAO report.

The FY1999 Defense Authorization Act directed DOD to submit a plan by March 31, 1999 for a system-wide redesign of the DOD's pharmacy system that would include a uniform formulary (or inventory of pharmaceuticals), a centralized database, and extend the pharmacy benefit to Medicare-eligible beneficiaries. The report, submitted in May, noted components of pharmacy benefit programs used by civilian plans that, if adopted, could lead to a uniform, cost-efficient DOD-wide pharmacy benefit—an integrated information system, uniform development and enforcement of pharmacy benefit policies, resource requirements tailored to a known population, and better integration of the pharmacy benefit with the total medical benefit. DOD noted, however, that some civilian practices are not viable for DOD because they would lead to additional out-of-pocket costs for beneficiaries. DOD did conclude that an integrated information system would be advantageous as it would permit screening for drug interactions and administrative efficiencies. A more consolidated system could also buy

pharmaceuticals in bulk quantities at reduced rates. In addition to management changes, other proposals viewed as beneficial by DOD include the establishment of a uniform policy for the use of generic substitutions and requiring the use of the National Mail Order Pharmacy for refills of pharmaceuticals to be used for more than 30 days. Even with such changes, DOD expects that any savings will only offset expected increases in pharmacy costs rather than result in actual savings. The report also discussed the pros and cons of providing a pharmacy benefit to over-65 retirees, suggesting that any expansion would have to be supported by additional funding.

The FY1999 Defense Authorization Act (Section 723) also required the establishment by October 1, 1999 of a demonstration project that would provide a pharmacy benefit to Medicare-eligible retirees in two separate geographic areas. DOD may collect premiums, deductibles, copayments, or other charges that would otherwise be collected from other beneficiaries. Reports to Congress on the results of the demonstration projects would be due at the end of 2000 and 2002. On August 16, 1999, DOD announced that the **Tricare Pilot Pharmacy Benefit** projects would be established beginning in the spring of FY2000, in Okeechobee, Florida and Fleming, Kentucky. The projects are open to retired military personnel and their dependents in these two areas who are Medicare-eligible and enrolled in Medicare Part B. Annual enrollment fees are $250. plus applicable co-payments.

The conference report (H. Rept. 106-301) on the FY2000 Defense Authorization Act (P.L. 106-65) requires that DOD establish "an effective, efficient, integrated pharmacy benefits program." Included in the program would be a uniform formulary of pharmaceutical agents based upon the relative clinical and cost effectiveness of the agents. Provision would be made for availability of pharmaceuticals not included in the uniform formulary when appropriate, but with additional cost sharing by the recipient. The conference report also mandates that DOD provide a study of a design for a comprehensive pharmacy benefit for Medicare-eligible retirees for submission to Congress by April 15, 2001 (presumably utilizing the results of the demonstration project that is to begin in October 1999).

LEGISLATION

Military health care issues are addressed in annual Defense authorization and appropriations bills; for additional background and the status of current legislation, see CRS Report RL30205, *Appropriations for FY2000: Defense*, by Stephen Daggett. For background on budget reconciliation legislation in the 105th Congress, see CRS Report 97-640, *Medicare: Budget Reconciliation Action in the 105th Congress*.

H.R. 205 (Moran)

Permits covered beneficiaries under the military health care system who are also entitled to Medicare to enroll in FEHBP. Introduced January 6, 1999; referred to Committees on Armed Services and Government Reform.

H.R. 1067 (Thornberry)

Provides for Medicare reimbursement of health care provided by DOD to beneficiaries over age 65 and permits them to enroll in FEHBP. Introduced March 10, 1999; referred to Committees on Ways and Means, Commerce, Armed Services, and Government Reform.

H.R. 1413 (Hefley)

Expands and makes permanent Medicare subvention demonstration projects. Introduced April 14, 1999; referred to Committees on Ways and Means and Commerce.

H.R. 2966 (Shows)

Provides coverage for military retirees and dependents over age 65 under the Federal Health Benefits Program and allows retirees and dependents over age 65 to participate in Tricare. Introduced September 28, 1999; referred to the Committees on Government Reform and Armed Services.

S. 915 (Gramm)

Expands and makes permanent Medicare subvention demonstration projects. Introduced April 29, 1999 and referred to the Committee on Finance.

FOR ADDITIONAL READING

U.S. Congressional Budget Office, *Paying for Military Readiness and Upkeep: Trends in Operation and Maintenance Spending*, September 1997.

—— *Restructuring Military Medical Care*, July 1995.

U.S. General Accounting Office, *Defense Health Program: Future Costs are Likely to Be Greater Than Estimated*, GAO/NSIAD-97-83BR, February 1997.

—— *Military Retirees' Health Care: Costs and Other Implications of Options to Enhance Older Retirees' Benefits*, GAO/HEHS-97-134, June 1997.

—— *Defense Health Care: Fully Integrated Pharmacy System Would Improve Service and Cost-Effectiveness*, GAO/HEHS-98-176, June 1998.

—— *Defense Health Care: Need for Top-to-Bottom Redesign of Pharmacy Programs*, GAO/T-HEHS-99-75, March 1999.